

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4413

## CERTIFICATE OF DEATH

04385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norrisville</b>		c. LENGTH OF STAY IN lb <b>11 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norrisville</b>		d. STREET ADDRESS <b>White Hall RD</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>	Middle <b>RUSH</b>	Last <b>ANDERSON</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>23</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 22, 1884</b>	9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months <b>74</b>	IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Madonna, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>J. Thomas Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Bettie Nelson</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-28-2352</b>		17. INFORMANT <b>Mary K. Anderson</b>		Address <b>White Hall, RD Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic lymphocytic leukemia</b> INTERVAL BETWEEN ONSET AND DEATH								
204.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Stewartstown, Pa.</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>18 Oct. 1958</b> to <b>22 April 1959</b> that I last saw the deceased alive on <b>22 April 1959</b> , and that death occurred at <b>6:30A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Reginald B. Gemmill</i>		ADDRESS (Street, city or town, state) <b>Stewartstown, Pa.</b>						
PHYSICIAN'S NAME (Type) <b>Reginald B. Gemmill</b>		DATE SIGNED <b>24 April 1959</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Bethel</b>		22d. LOCATION (City, town, or county) <b>Madonna</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles E. Kurt</i>		ADDRESS <b>Garrisonville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 27 1959</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Moore</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4414

## CERTIFICATE OF DEATH

04386

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Rural, Aberdeen</b>		c. LENGTH OF STAY IN lb <b>R.D. 3</b>		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <b>Rural, Aberdeen</b>			
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION <b>R.D. 3</b>		d. STREET ADDRESS <b>R.D. 3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FLORENCE</b>		First <b>F.</b>	Middle <b>BALDWIN</b>	Last <b>April</b>	Month <b>11</b>	Day <b>Year</b> <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 May 1933</b>	9. AGE (In years lost birthday) <b>25 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Ardy Smith</b>				14. MOTHER'S MAIDEN NAME <b>Irene Kenney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Raymond T. Baldwin, Havre de Grace, Md.</b>		Address <b>666 Green St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174X</b> DUE TO <i>Cerebral Embolism</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Pulmonary Infarction &amp; Metastasis - 3 days -</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c) <i>Carcinoma of Uterus &amp; Metastasis (Colostomy) 2 years -</i>							
INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes -</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1955, to <b>April 11, 1959</b> , that I last saw the deceased alive on <b>April 11, 1959</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank Wolbert, M.D.</i>							
ADDRESS (Street, city or town, state) <b>200 N. Union Ave.</b>							
DATE SIGNED <b>4/11/59</b>							
PHYSICIAN'S NAME (Type)		<b>Frank Wolbert, M.D.</b>					
Havre de Grace, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/13/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Smith Chapel Cemetery</b>		22d. LOCATION (City, town, or county) <b>R.D. Aberdeen, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. O'Barry</i>		ADDRESS <b>Tarring Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>APR 14 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04387

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchville</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchville</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Emma</b>		First	Middle	Last	4. DATE OF DEATH <b>Apr. 19 1959</b>	Month	Day	Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Mar. 9, 1882</b>	9. AGE (In years lost birthday) yrs. <b>77</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William A. Bodt</b>		14. MOTHER'S MAIDEN NAME <b>Annie A. Bodt</b>		Preston		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs., Dorothy Bodt, Churchville, Maryland.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (c)		<b>Congestive Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
		<b>Pneumonia</b>				<b>6 yr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>o/ work</b> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Churchville</b>		(County) <b>Md.</b> (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>April 18, 1959</b> , and that death occurred at <b>Churchville, Maryland</b> , on <b>April 19, 1959</b> , that I last saw the deceased alive on <b>April 18, 1959</b> , and that death occurred at <b>Churchville, Maryland</b> , on the date stated above.								ADDRESS (Street, city or town, State) <b>Churchville, Maryland</b>	DATE SIGNED <b>April 23, 1959</b>
ACTUAL SIGNATURE <b>J. Ralph Horky</b>									
PHYSICIAN'S NAME (Type) <b>J. Ralph Horky</b>		Churchville Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Smith's Chapel</b>		22d. LOCATION (City, town, or county) <b>Churchville, Harford, Md.,</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard McComas</b>		ADDRESS <b>Abingdon, Maryland.</b>		24a. REC'D BY REGISTRAR <b>Cirinus &amp; Thoma</b>		24b. REGISTRAR'S SIGNATURE <b>Cirinus &amp; Thoma</b>			
				DATE APR 23 '59					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1990, 6(1)

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#### ANSWER

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4416

### CERTIFICATE OF DEATH

04388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>HARFORD</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Fountain Green</b>		c. LENGTH OF STAY IN lb <b>5 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Fountain Green</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Churchville Road</b>				d. STREET ADDRESS <b>Churchville Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Walter T. Blevins</b>		First	Middle	Lost	4. DATE OF DEATH <b>April 18</b>	Month	Day	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 28, 1884</b>	9. AGE (In years lost birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>J. W. BLEVINS</b>				14. MOTHER'S MAIDEN NAME <b>NANCIE EVANS</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. —		17. INFORMANT <b>SASSIE Richardson BLEVINS</b>		Address <b>RD #2 Bel Air, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) <b>Chronic Hypertensive Cardio-vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m.      19 p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>April 18, 1955</b> , to <b>April 18, 1959</b> , that I last saw the deceased alive on <b>April 18, 1959</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Willard P. Hudson, M.D.</b> <b>Forest Hill, Maryland</b> <b>DATE SIGNED</b> <b>ACTUAL SIGNATURE</b> <b>Willard P. Hudson, M.D.</b> <b>Forest Hill, Maryland</b> <b>April 18, 1959</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Crab Creek Primitive Baptist</b>		22d. LOCATION (City, town, or county) <b>Sparta</b> (State) <b>N.C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Trotter</b>		ADDRESS <b>W. Broadway + W. 11th St. Bel Air, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 21-59</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Hudson</b>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4417

### CERTIFICATE OF DEATH

# 04389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Benson</i>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Benson</i>	
3. NAME OF DECEASED (Type or print) <i>Clara</i>		d. STREET ADDRESS <i>/</i>	
4. DATE OF DEATH <i>Apr. 1 19 1959</i>	Month Year	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 18, 1895</i>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <i>63 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Bush</i>		14. MOTHER'S MAIDEN NAME <i>Aliza Heimann</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mr. William S. Bowman,</i> Address <i>same</i>	
17. INFORMANT <i>Mr. William S. Bowman,</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>Congestive heart failure</i> <i>Arteriosclerosis CVD</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senile psychosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Apr. 1</i> , 1959, to <i>Apr. 1</i> , 1959, that I last saw the deceased alive on <i>Apr. 1 19 1959</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Kingsville, Md.</i> DATE SIGNED <i>Apr. 1 19 1959</i>	
ACTUAL SIGNATURE <i>William A. Tyson</i>		PHYSICIAN'S NAME (Type) <i>William A. Tyson</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/23/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
		24a. REC'D BY REGISTRAR DATE <i>APR 21 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

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HTABD HQ STAFF NCO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

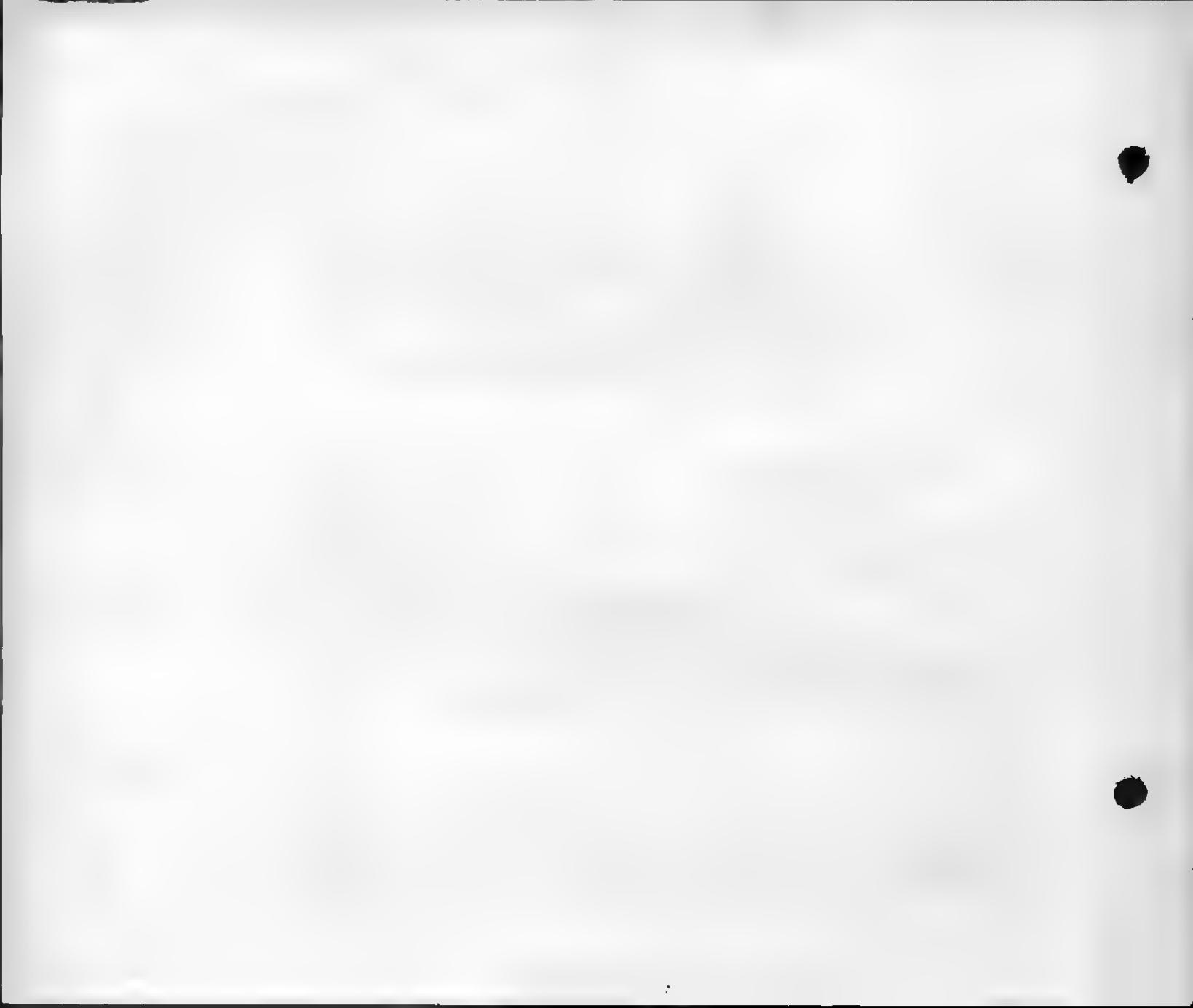
## CERTIFICATE OF DEATH

04390

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be submitted within 24 hours after death. Page may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal and any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen, Maryland</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen, Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Near Parsons Run</i>		d. STREET ADDRESS <i>Near Parsons Run</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Courtland Bowman Sr.</i>		First <i>John</i>	Middle <i>Courtland</i>
Last <i>Bowman Sr.</i>		4. DATE OF DEATH Month <i>Aug</i>	Day Year <i>2 1959</i>
S SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Aug. 5th 1889</i>
9 AGE (In years last birthday) <i>69 yrs.</i>		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Building Construction</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Carpenter Retired</i>	
10c BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Henry Bowman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lubinski</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>420-1</i>	
17. INFORMANT <i>Mrs. F. J. Ruppel Aberdeen, Md. #2, 2nd</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		 <i>Coronary Occlusion</i>	
(b) DUE TO <i>Coronary Arteriosclerosis</i>		2 days	
(c)		3 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-2-1959</i> to <i>8-2-1959</i> , that I last saw the deceased alive on <i>8-2-1959</i> , and that death occurred at <i>8-2-1959</i> M, from the causes and on the date stated above		ADDRESS (Street, City or town, state) <i>8 pm, 8th - Aberdeen, Md.</i>	
ACTUAL SIGNATURE <i>Peter P. Rodman, M.D.</i>		DATE SIGNED <i>8 pm, 8th - Aberdeen, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Peter P. Rodman, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/5/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>South Chapel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen, Md. #2, 2nd</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barrig Aberdeen, Maryland</i>		ADDRESS REC'D BY REGISTRAR DATE <i>APR 7 1959</i>	
		24b. REGISTRAR'S SIGNATURE <i>John G. Barrig</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4397

## CERTIFICATE OF DEATH

04391  
Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Severna Park</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hause de Grace</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Noert East</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hospital</b>		d. STREET ADDRESS <b>RT #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Clemson</b>	Middle	Last <b>Brown</b>	4. DATE OF DEATH Month <b>April</b>	Day <b>13</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept 9 1901</b>	9. AGE (In years lost birthday) <b>57 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ind</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Webster</b>		14. MOTHER'S MAIDEN NAME <b>HARRIET McMillen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>No</b> (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>222-07-0849</b>		17. INFORMANT <b>Mrs Clemson Brown North East Rd 1 Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Drake Dmyer and died infarction		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Rising Sun</b> (County) <b>Md</b> (State) <b>Md</b>	
21. I certify that I attended the deceased from <b>April 1, 1959</b> to <b>April 13 1959</b> , that I last saw the deceased alive on <b>APRIL 13, 1959</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Neil Taylor</b> M.D. ADDRESS (Street, city or town, state) <b>Rising Sun, Md</b> DATE SIGNED <b>4/13/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-16-1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Bank Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Calvert, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Frank</b>		ADDRESS <b>North East Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 15 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thrua</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04392

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

THIS CERTIFICATE should be filed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used for burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Harford		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Harmonde Grace Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Harmonde Grace	
D.O.A. Harford Memorial Hosp				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First,	Middle	Lost	4. DATE OF DEATH	Month	Year
F		C			April	18	1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
F		C	<input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 2, 1883	75 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Labor		Sparkler Retired		Harford Grace Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
John		Sarah Elizabeth Peace		Ms Madalene Williams-Harmonde Grace Md			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
—		212-22-3668		Fracture Skull			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fracture Skull					
818X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)					
(a), stating the underlying cause last.		DUE TO					
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 7:30 p.m. 4-18 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County) (State)	
				Greenhouse		Harford Grace Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		4-18-59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		4-22-1959		St. Francis' Cem.		Harford Grace Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
R. Madison Mitchell, Harmonde Grace, Md.				DATE APR 22 '59		Arthur S. Thomas	
VS ATSM 5M 2/57							



FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. A should be for **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT 11:59  
SM 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4419 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen		c. LENGTH OF STAY IN 1b		a. STATE Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Brush Chapel Road		d. STREET ADDRESS		b. COUNTY Harford	
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		f. IS RESIDENT ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	o. Last	Cullum	4. DATE OF DEATH	Month Apr 11
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	19 January 1879	Month Day 3	Year 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE, (In years last birthday) 80 yrs	
Carpenter (Ret)		Carpentry		Maryland		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME		John L. Cullum		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or date of service)		16. SOCIAL SECURITY NO 218-05-0519		17. INFORMANT James J. Cullum Address 302 Pine St.	
No						Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO GSW mouth							
Conditions, if any, which gave rise to immediate cause (b) _____							
IMMEDIATE CAUSE (a) 776X DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH,		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot self with shot gun					
20c. TIME OF INJURY Month, Day, Year How 2:00 p.m. 4-3 1959 at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Aberdeen Rd. Ford Md		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gerald E Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Bel Air, Md 7-3-59	
EXAMINER'S NAME (Type) Gerald E Palmer		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/59		22c. NAME OF CEMETERY OR CREMATORIAL Calvary Cemetery		22d. LOCATION (City, town, or county) R.D. Bel Air, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G Farney		ADDRESS Tarring Funeral Home		24a. REC'D BY REGISTRAR APR 8 '59		24b. REGISTRAR'S SIGNATURE Arlene S. Thomas	
		Aberdeen, Md.					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4399

## CERTIFICATE OF DEATH

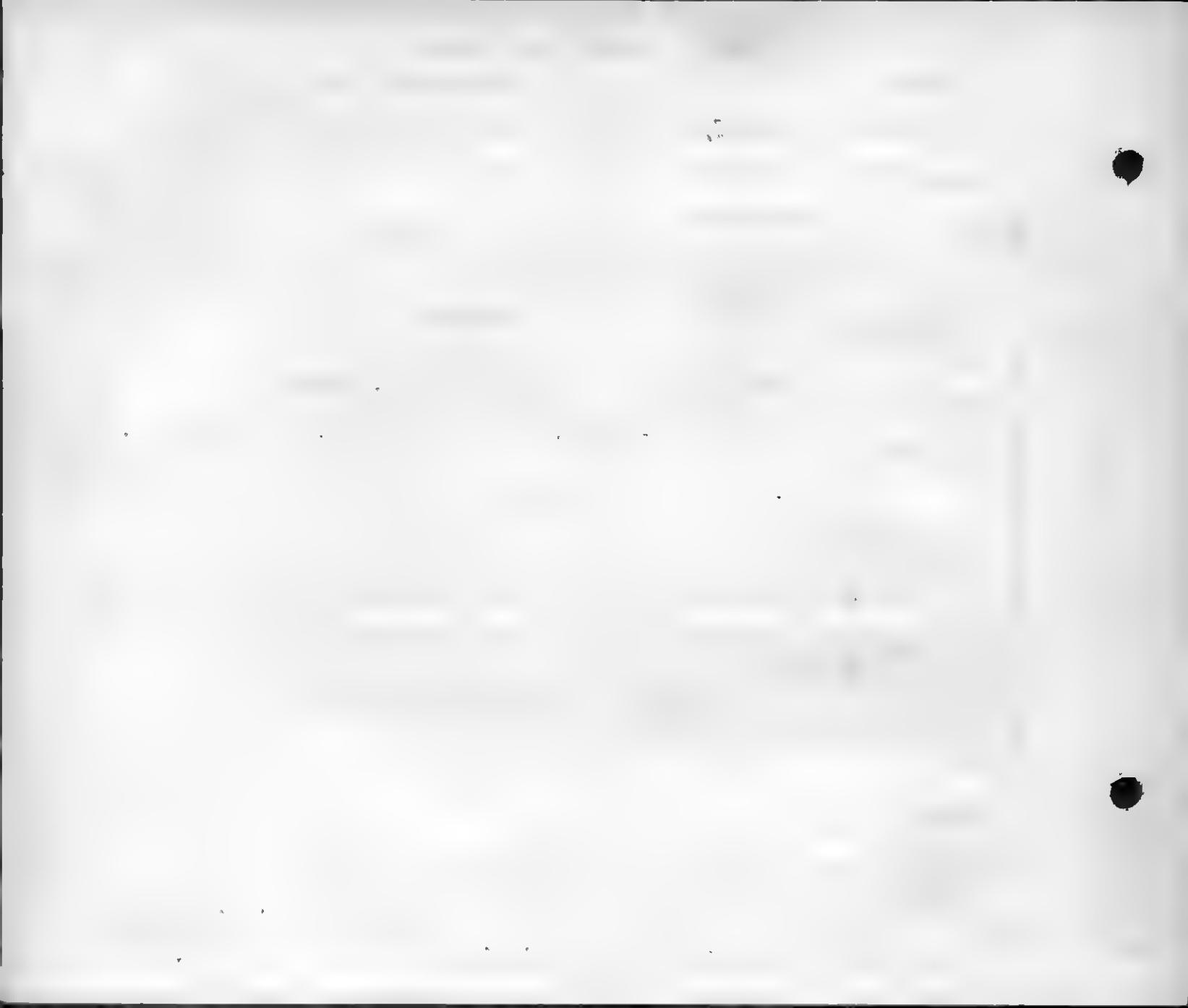
04394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hagerstown</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Cecil</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Aberdeen Memorial Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Thomas</i>	Middle <i>Thomas</i>	Last <i>Davidson</i>	4. DATE OF DEATH <i>March 31, 1959</i>	Month <i>March</i>	Day <i>31</i>	Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 25, 1887</i>	9. AGE (In years lost birthday) <i>71 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Thomas Devonshire</i>		14. MOTHER'S MAIDEN NAME <i>Clara A. Founds</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-20-1929</i>		17. INFORMANT <i>Mrs David Curry, Aberdeen, Md. Rural</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Primary carcinoma of gall bladder</i>						INTERVAL BETWEEN ONSET AND DEATH <i>?</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>(b) _____ (c) _____</i>		DUE TO <i>—</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>(Cirrhosis of liver &amp; Hypostatic pneumonia)</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>—</i>						
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	Month <i>Mar</i>	Year <i>1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>	
21. I certify that I attended the deceased from <i>Mar 19, 1959</i> to <i>Mar 21, 1959</i> , that I last saw the deceased alive on <i>Mar 21st, 1959</i> , and that death occurred at <i>4:45 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward C. Lee, M.D.</i>				ADDRESS (Street, city or town, state) <i>112 W. Prince St., Perryville, Md.</i>		DATE SIGNED <i>4/22/59</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-24-1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rose Bank Cemetery</i>	22d. LOCATION (City, town, or county) <i>Calvert, Md.</i>	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Patterson, Jr.</i>	ADDRESS <i>Perryville, Md.</i>	24a. REGISTRY REGISTRATION <i>APR 22 1959</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Miller</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4420

## CERTIFICATE OF DEATH

04395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		Maryland Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Bush Chapel Road.		d. STREET ADDRESS		Bush Chapel Road	
3. NAME OF DECEASED (Type or print)		First Albert	Middle Keyser	Last Ford.	DATE OF DEATH	Month Apr	Day 28 Year 1959
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/1877		9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Thornton Ford		14. MOTHER'S MAIDEN NAME Harriett Stockhouse					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO None		17. INFORMANT Mildred Cole (daughter)		Address Aberdeen Rd. 208 W Bel Air Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) DUE TO Cerebral Vascular Accident. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arterio sclerotic Heart Disease (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 1, 1959, to April 27, 1959, that I last saw the deceased alive on April 24, 1959, and that death occurred at 5:30 P.M. from the causes and on the date stated above						ADDRESS (Street, city or town, state) 114 W. Bel Air Ave, Aberdeen	
ACTUAL SIGNATURE Andre Weiss M.D.						DATE SIGNED	
PHYSICIAN'S NAME (Type) Andre Weiss M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF APR 1959		22c. NAME OF CEMETERY OR CREMATOR Y Spesutia Cemetery		22d. LOCATION (City, town, or county) Perryman Rd.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barry Aberdeen, Maryland		ADDRESS		24a. REC'D BY REGISTRAR APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4400

## CERTIFICATE OF DEATH

04396  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Md</u>		c. LENGTH OF STAY IN 1b <u>16 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem. Hospital</u>		e. STREET ADDRESS <u>Route 3 Box 117</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Frank Franczkiewicz</u>		First	Middle	DATE OF DEATH <u>Nov. 15, 1902 36</u>	Month Day Year <u>April 7 1959</u>
4. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1902 36</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beverage</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>(Deceased) Rose Dominski</u>		14. MOTHER'S MAIDEN NAME <u>(Deceased) Frank Franczkiewicz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-7542</u>		17. INFORMANT <u>Marie Franczkiewicz</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hours</u>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <u>Cerebral Hemorrhage</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Phaeochromocytoma</u>		DUE TO <u>Phaeochromocytoma</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Hanover</u> (County) <u>Harford Co.</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>4/7/59</u> to <u>4/7/59</u> , that I last saw the deceased alive on <u>April 7, 1959</u> , and that death occurred at <u>Hanover</u> M.D. on <u>4/7/59</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>4/7/59</u>					
ACTUAL SIGNATURE <u>Edward Lee, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Edward Lee, M.D.</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>HOLY ROSARY CEM</u>	
22d. LOCATION (City, town or county) <u>BALTIMORE Co. MD</u>		(State)			
23 FUNERAL DIRECTOR'S SIGNATURE <u>John M. Herbertson 401st Street</u>		ADDRESS <u>1100 40th Street, Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 14 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Isaac</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in an event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4401

## CERTIFICATE OF DEATH

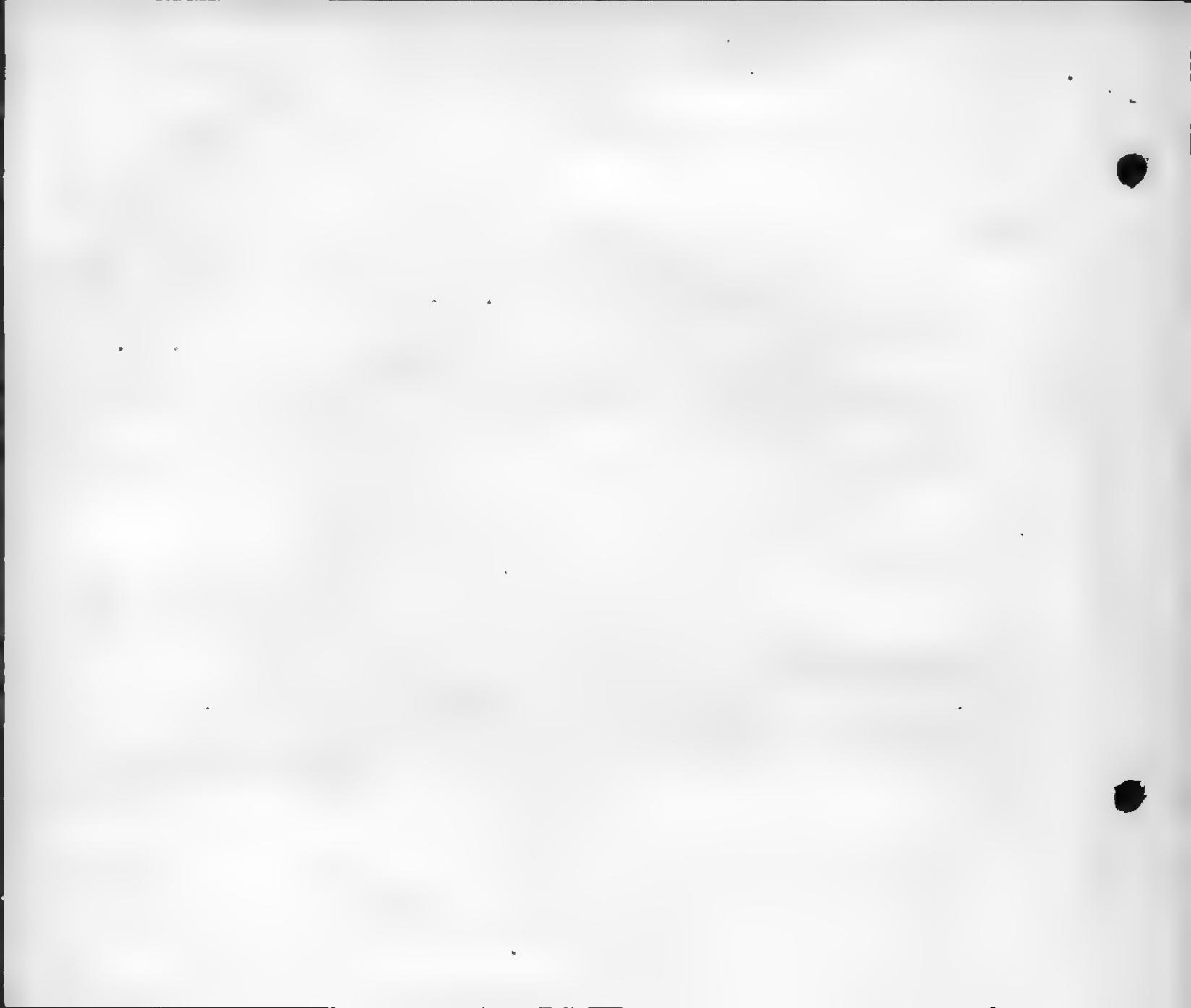
04397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanover</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holyoke-Grace</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hanover Memorial Hospital</i>		e. STREET ADDRESS <i>353 Carter St</i>	
f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Helen</i>	Middle <i>Thomas</i>	Last <i>Fyle</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb., 19, 1909</i>
9. AGE (In years last birthday) yrs. <i>50</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. DATE Month Day Year <i>4 23 1959</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Randall Bloodsworth</i>		14. MOTHER'S MAIDEN NAME <i>Annie Dashiell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Leon Fyle, 353 Carter St, Hanover, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia and Acidosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Metastatic Carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>	
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Squamous Cell Ca. of cervix</i>		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> off work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Aberdeen</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Feb. 2nd, 1959</i> to <i>April 23rd, 1959</i> , that I last saw the deceased alive on <i>April 23rd, 1959</i> , and that death occurred at <i>4:50 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Edward C. Logue, M.D., Holyoke-Grace, Aberdeen, Md.</i>	
ACTUAL SIGNATURE <i>Edward C. Logue, M.D.</i>		DATE SIGNED <i>4/23/59</i>	
PHYSICIAN'S NAME (Type) <i>Edward C. Logue, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/26/59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial Gardens</i>		22d. LOCATION (City, town, or county) (State) <i>Bel Air, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barnes</i>		Tarr <del>1000</del> Funeral Home Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE <i>Craig S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
442 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04398

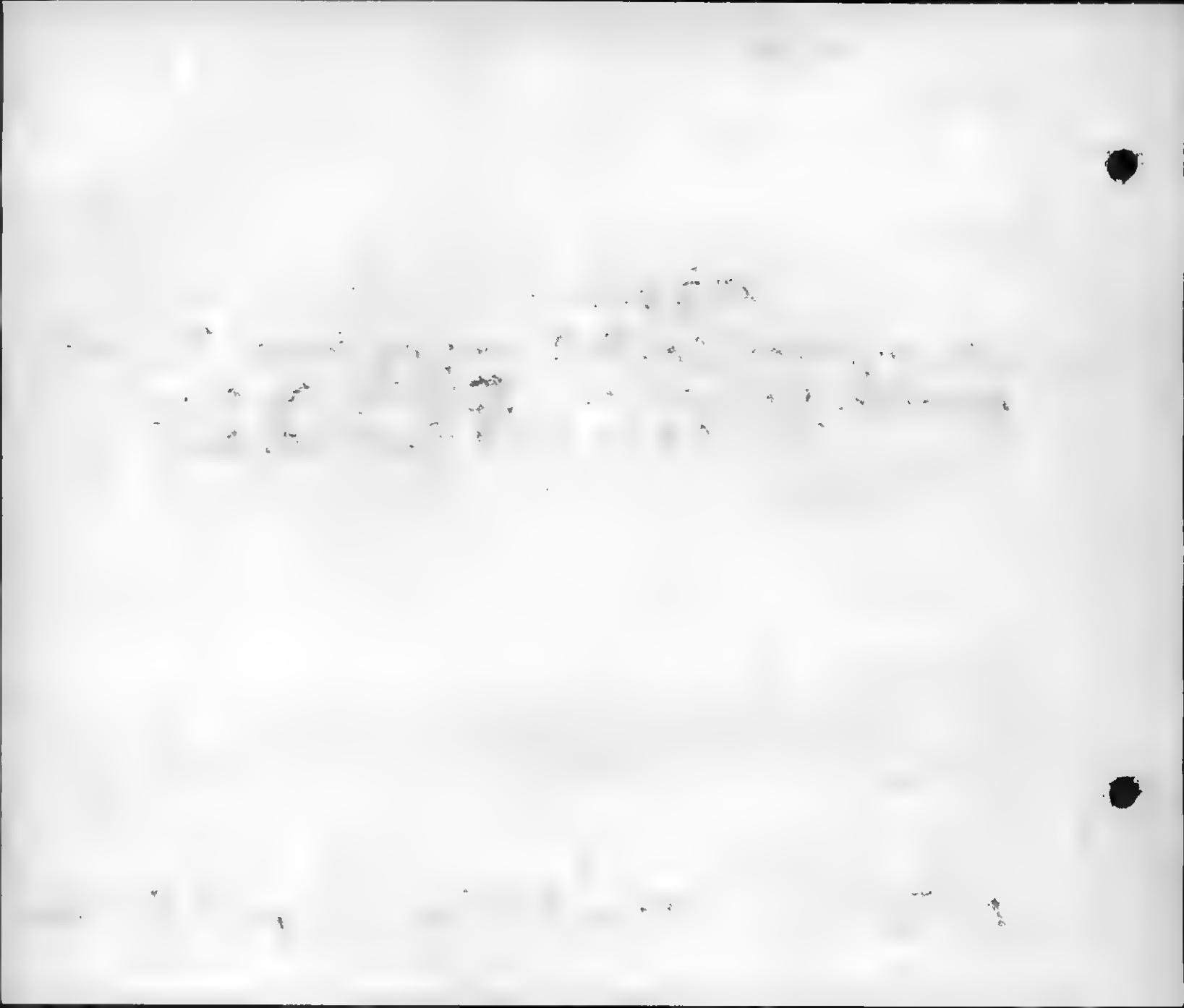
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen		c. LENGTH OF STAY IN 1b		d. STATE <input checked="" type="checkbox"/> Md b. COUNTY <input checked="" type="checkbox"/> Harford	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		R.D. 2		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x A.berdeen	
3. NAME OF DECEASED (Type or print)		First Middle Lost		4. DATE OF DEATH		Month Day Year	
5. SEX <input checked="" type="checkbox"/> M		6 COLOR OR RACE <input checked="" type="checkbox"/> W NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH		7 <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> b. DATE OF BIRTH		9 AGE (In years lost birthday) <input checked="" type="checkbox"/> 41 yrs IF UNDER 1YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if red.)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)		12 CITIZEN IN WHAT COUNTRY?	
Building attendant		C. & P. Tel Co		Harford Co., Md.		U.S.A.	
13. FATHER'S NAME <i>Joseph J. Gallion</i>		14. MOTHER'S MAIDEN NAME <i>Estella Hughes</i>		15. INFORMANT <i>Russell J. Gallion</i>		16. SOCIAL SECURITY NO. <i>213-28-3279</i>	
17. WAS DECEASED EVER IN THE ARMED FORCES (If yes, give rank and dates of service)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SW Cerebrum</i> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
INTERVAL BETWEEN ONSET AND DEATH _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Shot self with shot gun</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>4 - 23 1959</i>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Aberdeen</i> (County) <i>Harford</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Gerald L. Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		EXAMINER'S NAME (Type) <i>Gerald L. Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL OR CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 26 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Run Cem</i>		22d. LOCATION (City, town, or county) <i>Harford Co., Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey Hartington MD</i>		ADDRESS <i>100 E. Main St.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Evans</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	
				DATE APR 28 '59			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4402

## CERTIFICATE OF DEATH

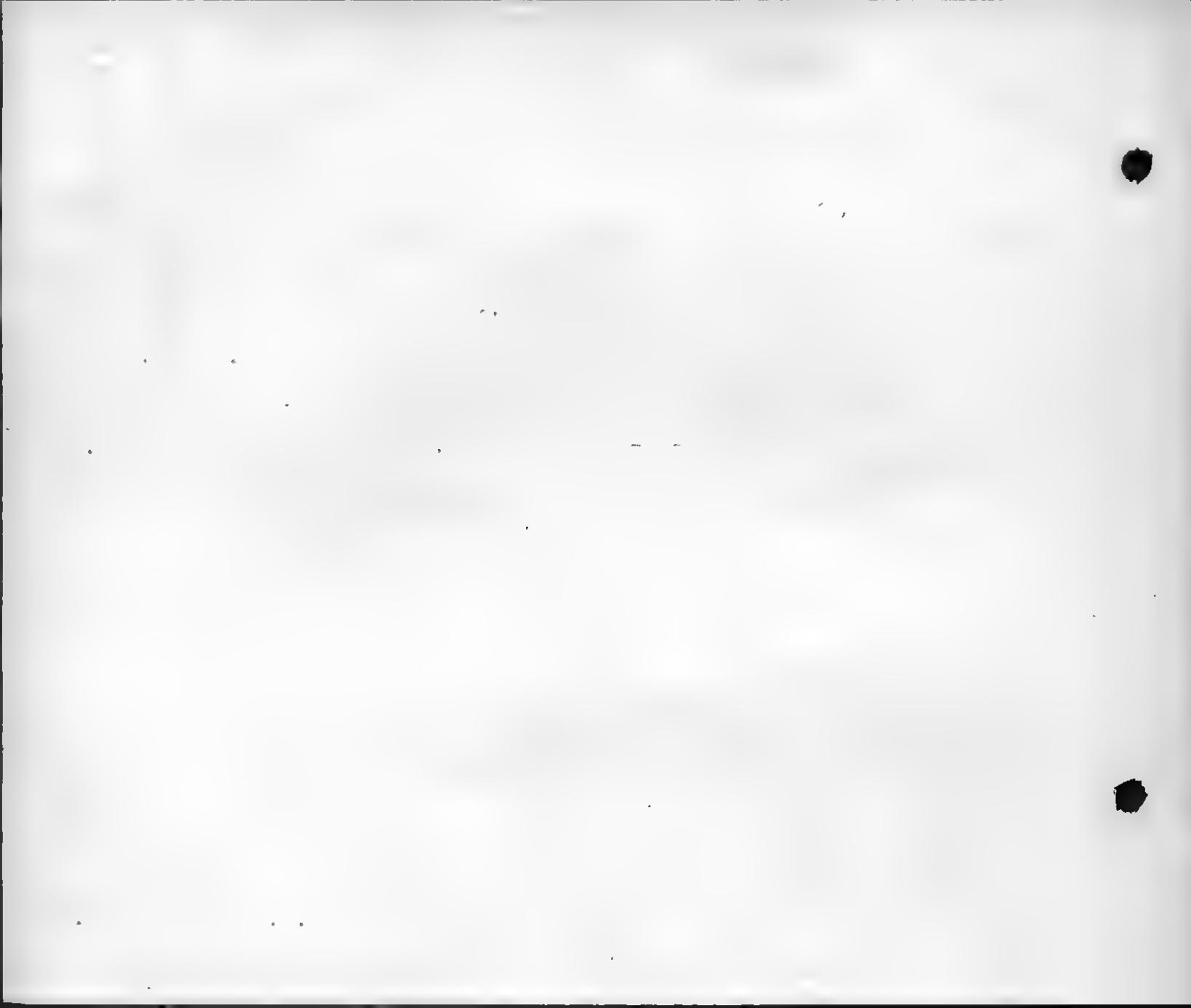
04399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. LENGTH OF STAY IN 1b <i>1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Jersey Ave.</i>		e. STREET ADDRESS <i>1 Jersey Ave</i>	
f. DATE OF DEATH <i>Feb. 19 1959</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Maggie</i>	First <i>Maggie</i>	Middle <i>Holland</i>	Last <i>Holland</i>
4. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb., 6, 1904</i>
9. AGE (In years (last birthday)) <i>55</i>	10. IF UNDER 1 YEAR Months <i>7</i>	11. IF UNDER 24 HRS Days <i>8</i>	12. Year <i>19 59</i>
10a. JSJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland Penna.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13. FATHER'S NAME <i>Robert Holland</i>	14. MOTHER'S MAIDEN NAME <i>Estella Black</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No</i>	16. SOCIAL SECURITY NO <i>222-10-7929</i>	17. INFORMANT <i>Agnes A. Carney</i>	Address 512 Lombard St. <i>Wilmington, Del.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1810</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
Hydrochormic Anemia Bleeding from Bladder Carcinoma of Bladder INTERVAL BETWEEN ONSET AND DEATH <i>5 mo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 _____, to _____, 19 _____, that I last saw the deceased alive on _____, 19 _____, and that death occurred at _____, 19 _____. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Beth P. Rodman, M.D.</i>			
DATE SIGNED <i>4/10/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/11/59</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Union Methodist Cemetery, R.D. Aberdeen, Md.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Taylor &amp; Ewing Funeral Home</i>		24a. REC'D BY REGISTRAR DATE <i>PR 14 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traub</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4422

## CERTIFICATE OF DEATH

04400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE <i>Md</i>		If institution: residence before admission b. COUNTY <i>Harford</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Darlington</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Darlington</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Darlington</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>W</i>	Last <i>Hofkins</i>	4. DATE OF DEATH <i>April 20, 1959</i>	Month <i>April</i>	Day <i>20</i>	Year <i>1959</i>			
5. SEX a. COLOR OR RACE <i>Male White</i>		7. MARRIED WOMANED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7, 1873</i>	9. AGE (In years at last birthday) <i>85</i>	10. IF UNDER 1 YEAR yrs. <i>0</i>	11. IF UNDER 24 HS. Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>	
10a. OCCUPATION (Give kind of work done during most working life, even if retired) <i>Retired dairy farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Harford Co., Md.</i>		11. PLACE OF FOREIGN COUNTRY <i>V.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>Frank Hofkins</i>		14. MOTHER'S MAIDEN NAME <i>Annie Harper</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give date of entry and date of service) <i>No</i>		16. SECURITY NO <i>Mo 3616</i>		17. INFORMANT <i>Mo Isabelle Brown</i>		Address <i>Darlington, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Arteriosclerosis</i> DUE TO (c)						INTAKE/EEG CONST AND DEATH 2000					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes</i>						10 am					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Darlington</i>		(County) <i>Harford Co., Md.</i>		(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>May 1947</i> to <i>April 20, 1959</i> , that I last saw the deceased alive on <i>April 19, 1959</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dudley Phillips Jr.</i> M.D. ADDRESS (Street, city or town, state) <i>Darlington, Md.</i> DATE SIGNED <i>2nd 4/20/59</i>											
22a. BURIAL, Cremation <input checked="" type="checkbox"/>		22b. DATE THEREOF <i>April 23, 1959</i>		22c. NAME OF CEMETERY, CREMATORIUM <i>Darlington Cemetery</i>		22d. LOCATION (City, town, or county) <i>Harford Co., Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey, Darlington, Md.</i>		ADDRESS <i>H. S. Bailey, Darlington, Md.</i>		REC'D BY REGISTRAR DATE <i>APR 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur &amp; Anna</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be rejoined by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4403

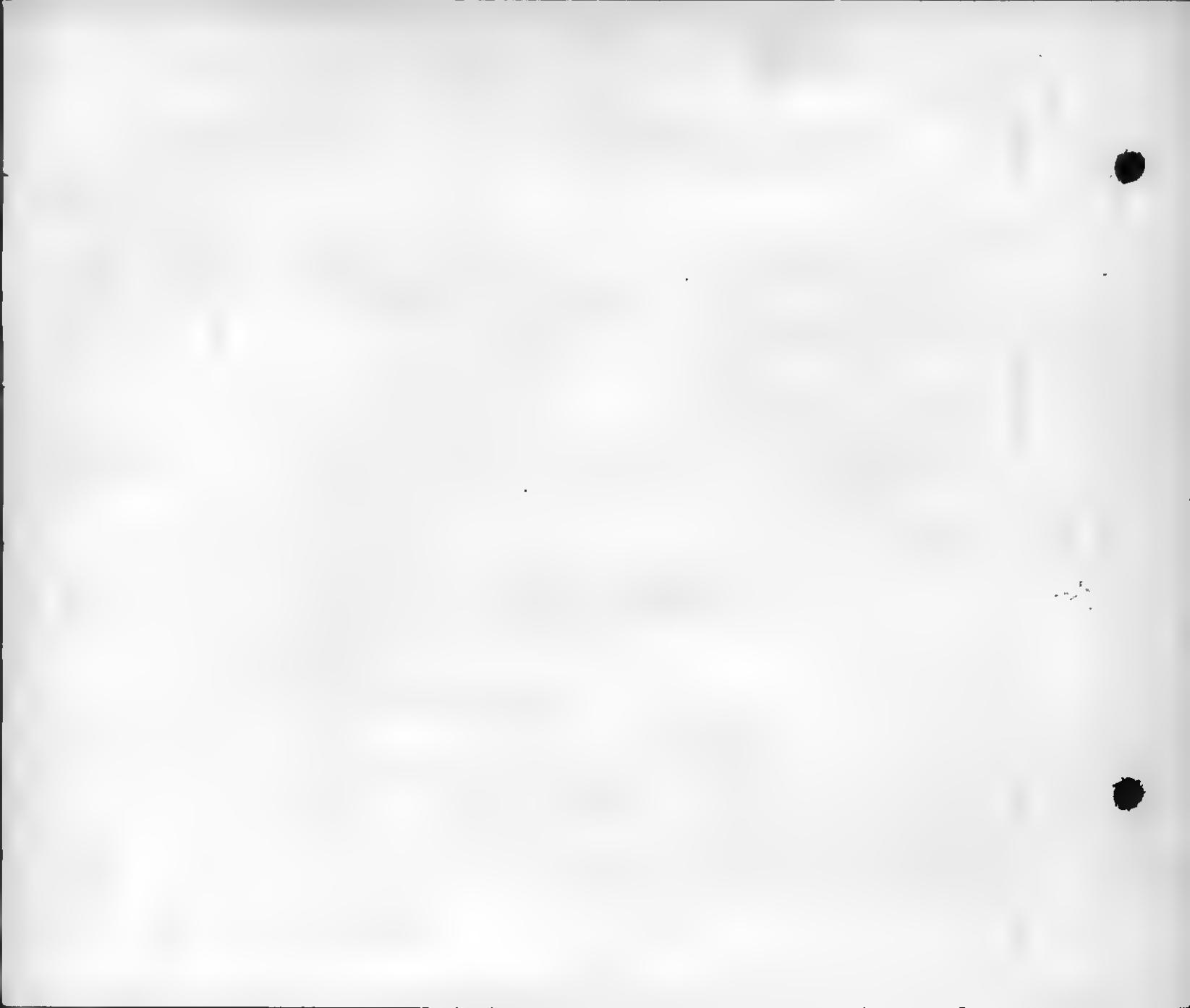
## CERTIFICATE OF DEATH

04402

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Havre de Grace</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Havre de Grace</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 16 <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		d. STREET ADDRESS <i>1563 OTSEGO ST.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Havre de Grace Memorial Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>ANNA</i>		First <i>Reynolds</i> Middle <i>Kieferle</i> Last <i>Lost</i>		4. DATE OF DEATH <i>April 6</i>		Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>JULY 20, 1883</i>		9. AGE (In years lost birthday) <i>75 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Thomas Reynolds</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Schutt</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO <i>- - - - -</i>		17. INFORMANT <i>Mrs. Wm. R. Speer, Spouse</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i>		DUE TO <i>X</i>		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Cardio-Renal disease</i>		DUE TO (b)							
DUE TO (c)		DUE TO <i>Cardio-Renal disease</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Havre de Grace</i>		20f. (City or town) <i>Havre de Grace</i>		(County) <i>Havre de Grace</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Apr. 1, 1959</i> to <i>Apr. 6, 1959</i> , that I last saw the deceased alive on <i>Apr. 6, 1959</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Havre de Grace Md.</i>		DATE SIGNED	
ACTUAL SIGNATURE <i>C. L. Lewis M.D.</i>		M.D.							
PRINTED NAME (Type) <i>C. L. Lewis M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>APR. 9, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Angel Hill</i>		22d. LOCATION (City, town, or county) <i>Havre de Grace</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell</i>		ADDRESS <i>Havre de Grace Md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04403

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>5 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 Havre de Grace</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private home</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Caroline M Lilley</b>		First	Middle	Lost	4. DATE OF DEATH Month <b>4 23</b>	Day	Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 10, 1883</b>	9. AGE (In years last birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Biddle</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Brower</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs Carleton Robertson</b>		Address <b>Havre de Grace, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>arterio sclerosis cerebral</b> 2 galls DUE TO (c) <b>Generalized arterio sclerosis</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Jan 1959</b> to <b>April 23, 1959</b> , that I last saw the deceased alive on <b>April 23, 1959</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>John L. Woodward M.D.</b> ADDRESS (Street, city or town, state) <b>407 S. Lincoln Ave Havre de Grace, Md</b> DATE SIGNED <b>4/25/59</b> PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-26-1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. French</b>		



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this time, it may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, it may be retained by the attending physician and completely filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

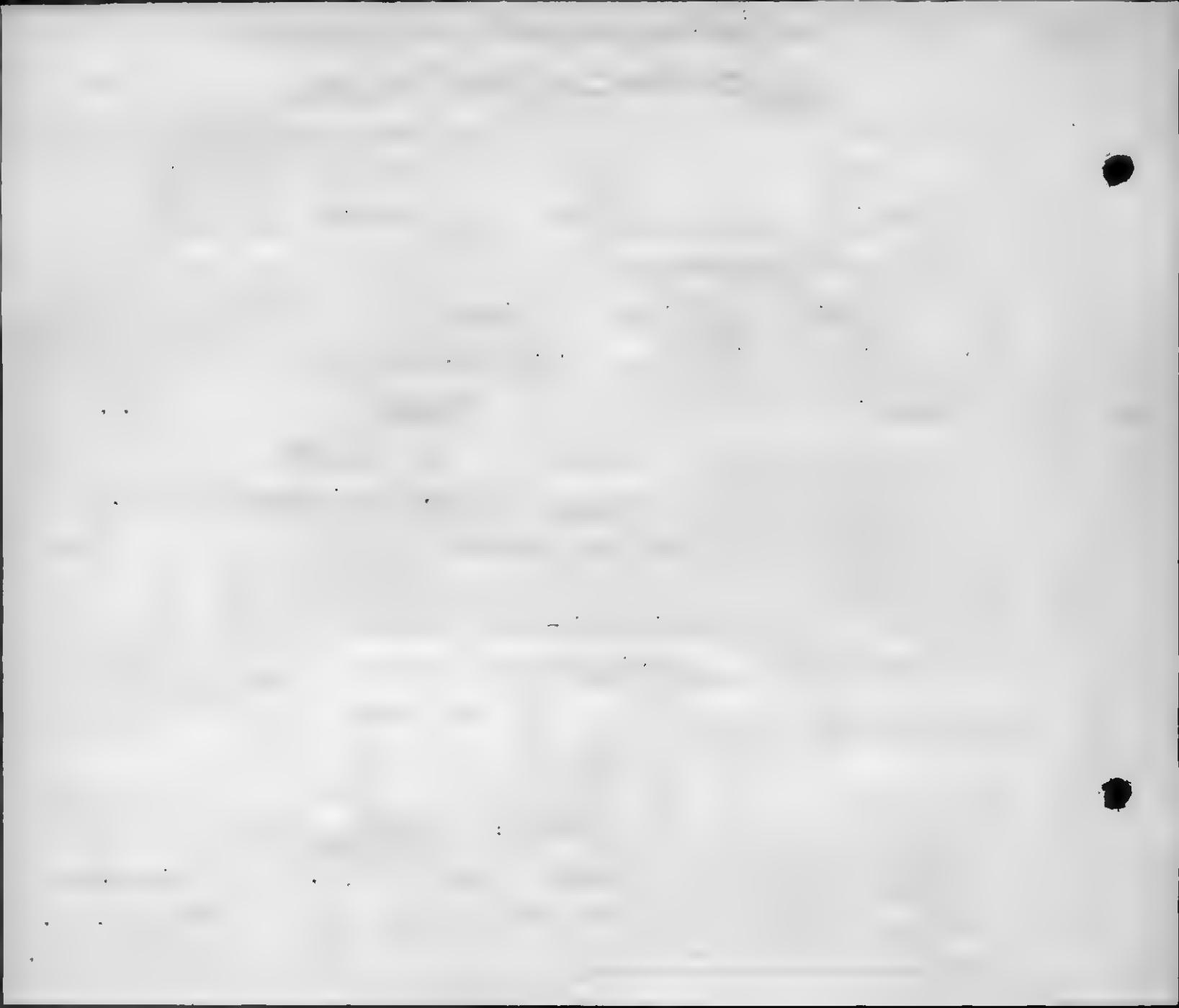
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**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****4405 CERTIFICATE OF DEATH**

04404

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place) 2 weeks		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Maryland Cecil Perryville (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Harford Convalescent Home</b>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <b>Alexander Jackson Little</b>				4. DATE OF DEATH <b>April 20 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Widowed</b>	8. DATE OF BIRTH <b>February 21, 1873</b>	9. AGE last birthday <b>86 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
13. FATHER'S NAME <b>James Little</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>				16. SOCIAL SECURITY NO. <b>17. INFORMANT &amp; ADDRESS Mrs. John Little, Perryville, Md.</b>			
18. MEDICAL CERTIFICATION <b>IMMEDIATE CAUSE (A) Lobar Pneumonia, terminating ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Chronic Cardio-vascular Disease</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Senile Dementia</b>							
? ?							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 9, 1959, to April 20, 1959, that I last saw the deceased alive on April 19, 1959, and that death occurred at 9:00 PM, from the causes end on the date stated above. SIGNATURE <i>Willard Patterson</i> M.D. ADDRESS (Street, city, town, state) DATE SIGNED Forest Hill Md. April 21, 1959							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>4-23-59</b>		NAME OF CEMETERY OR CREMATORIUM <b>Principio Cemetery</b>		LOCATION (City, town, or county) (State) <b>Principio Furnace, Md.</b>	
24. REC'D BY REGISTRAR DATE APR 2 4 '59		REGISTRAR'S SIGNATURE <i>Civilla S. Thorne</i>					
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		Perryville, Md. <i>Willard Patterson Son</i>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4423

## CERTIFICATE OF DEATH

04405

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Aberdeen</b>		c. LENGTH OF STAY IN lb <b>c</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. #1</b>		e. STREET ADDRESS <b>R.D. #1</b>			
3. NAME OF DECEASED (Type or print) <b>SUSAN</b>		First <b>M.</b>	Middle <b>LOCHARY</b>		
4. DATE OF DEATH <b>April 19 1889</b>	Month <b>April</b>	Day <b>10</b>	Year <b>1889</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 August 1889</b>		
9. AGE (In years (last birthday) <b>69</b>	10. IF UNDER 1 YEAR Months <b>69</b>	11. IF UNDER 24 HRS Days <b>69</b>	12. IF UNDER 24 HRS Hours <b>69</b>		
13. CITIZEN OF WHAT COUNTRY <b>USA.</b>	14. FATHER'S NAME <b>E. Hall Harkins</b>	15. MOTHER'S MAIDEN NAME <b>Ella A. Mahan</b>	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
17. SOCIAL SECURITY NO <b>Address R.D. 1, Aberdeen, Md.</b>	18. INFORMANT <b>Mrs. Albert Jersey Jr.</b>	19. INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Non-txic Goiter</b> (b) DUE TO (c)		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>arteriosclerotic Disease eyes</b>	22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
23. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] <b>Non-txic Goiter</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Churchville, Md.</b>	20f. (City or town) <b>Churchville</b>	(County) <b>Churchville</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>April 8, 1959</b> , to <b>April 19, 1959</b> , that I last saw the deceased alive on <b>April 8, 1959</b> , and that death occurred at <b>2:55 p.m.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. Ralph Horky, M.D.</b>					
PHYSICIAN'S NAME (Type) <b>J. Ralph Horky, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/13/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Ignatius Cemetery</b>	22d. LOCATION (City, town, or county) <b>R.D., Bel Air, Maryland</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tarring Funeral Home</b>	24a. ADDRESS <b>Aberdeen, Md.</b>	24b. REC'D BY REGISTRAR DATE <b>APR 14 '59</b>	24c. REGISTRAR'S SIGNATURE <b>Civilla S. Horne</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Form 2-14-57 et

4406

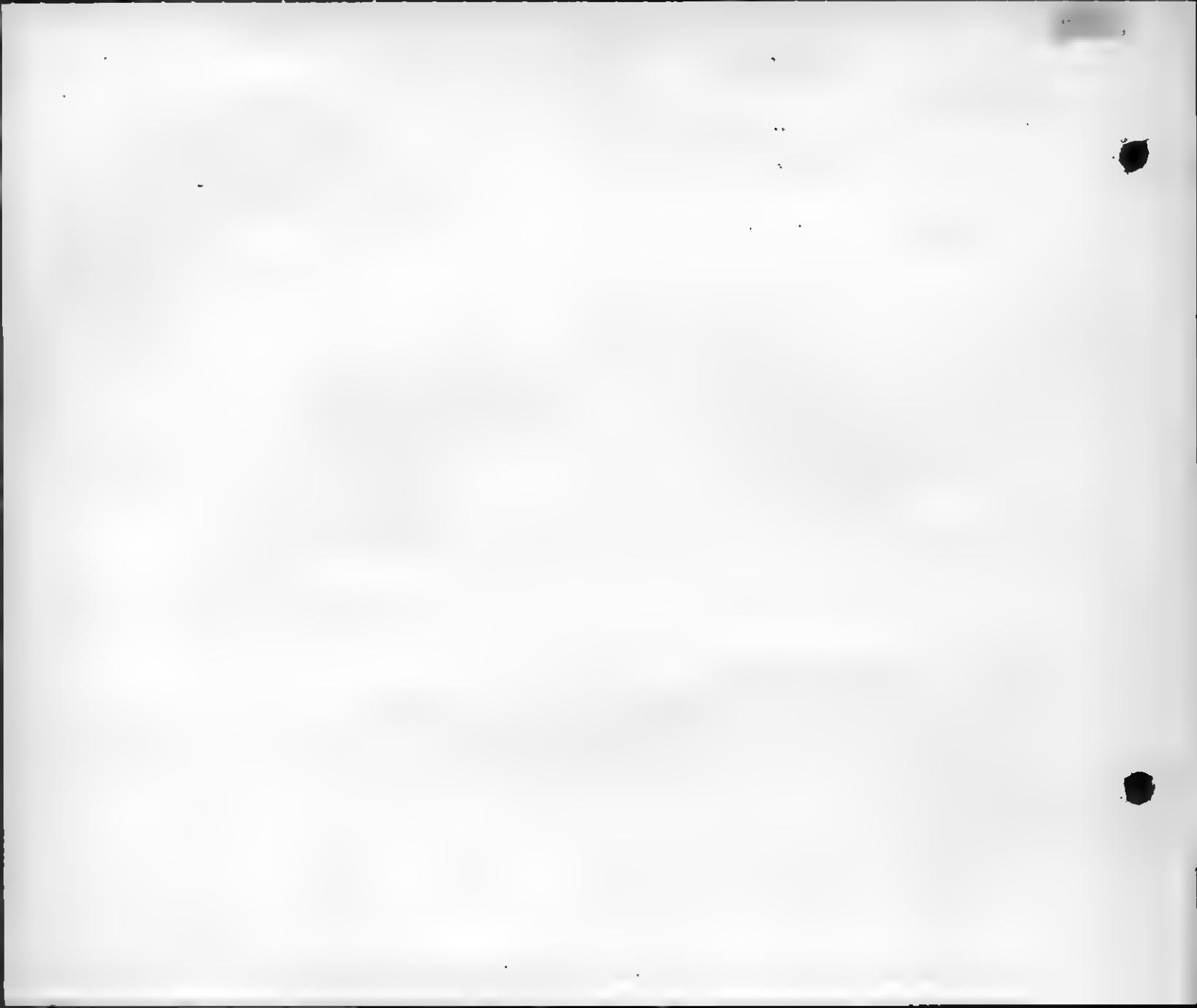
## CERTIFICATE OF DEATH

04406

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-troupe permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

PLACE OF DEATH a. COUNTY <i>Hanford</i>		b. CITY OR TOWN: (If outside corporate limits, write RURAL and give nearest town) <i>Hanover Chase</i>		c. LENGTH OF STAY IN 1b <i>9 mo.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Hanford</i>									
d. CITY OR TOWN: (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b <i>Hanover Chase</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN: (If outside corporate limits, write RURAL and give nearest town) <i>Hanover Chase</i>													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		d. STREET ADDRESS <i>621 Freedom</i>		4. DATE OF DEATH <i>4/5/59</i>		Month Day Year 19											
3. NAME OF DECEASED (Type or print) <i>Samuel Lunsford</i>		First Middle Last		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1885</i>		9. AGE (In years less birthday) <i>91/2/1885</i>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>											
13. FATHER'S NAME <i>Louis Lunsford</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Richard Lunsford</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i>		19. INTERVAL BETWEEN ONSET AND DEATH									
DUE TO <i>002</i>		b) <i>Pulmonary Tuberculosis (Arrested)</i>		c) <i>Generalized Arteriosclerosis</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>April 1, 1959</i> , to <i>April 4, 1959</i> , that I last saw the deceased alive on <i>April 4, 1959</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above.		22. ACTUAL SIGNATURE <i>George J. Stansbury</i>		23. PHYSICIAN'S NAME (Type) <i>George J. Stansbury</i>		24. ADDRESS (Street, city or town, state) <i>M.D. 569 Randolph St., Hanover Chase Md. 4/1/59</i>		25. DATE SIGNED <i>4/1/59</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>4/8/59</i>		22b. DATE THEREOF <i>4/8/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. James</i>		22d. LOCATION (City, town, or county) <i>Hanover Chase Md.</i>		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dwight L. Ray Hanover Chase</i>		24a. ADDRESS <i>—</i>		24b. REC'D BY REGISTRAR DATE APR 8 '59		24c. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>											



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4424

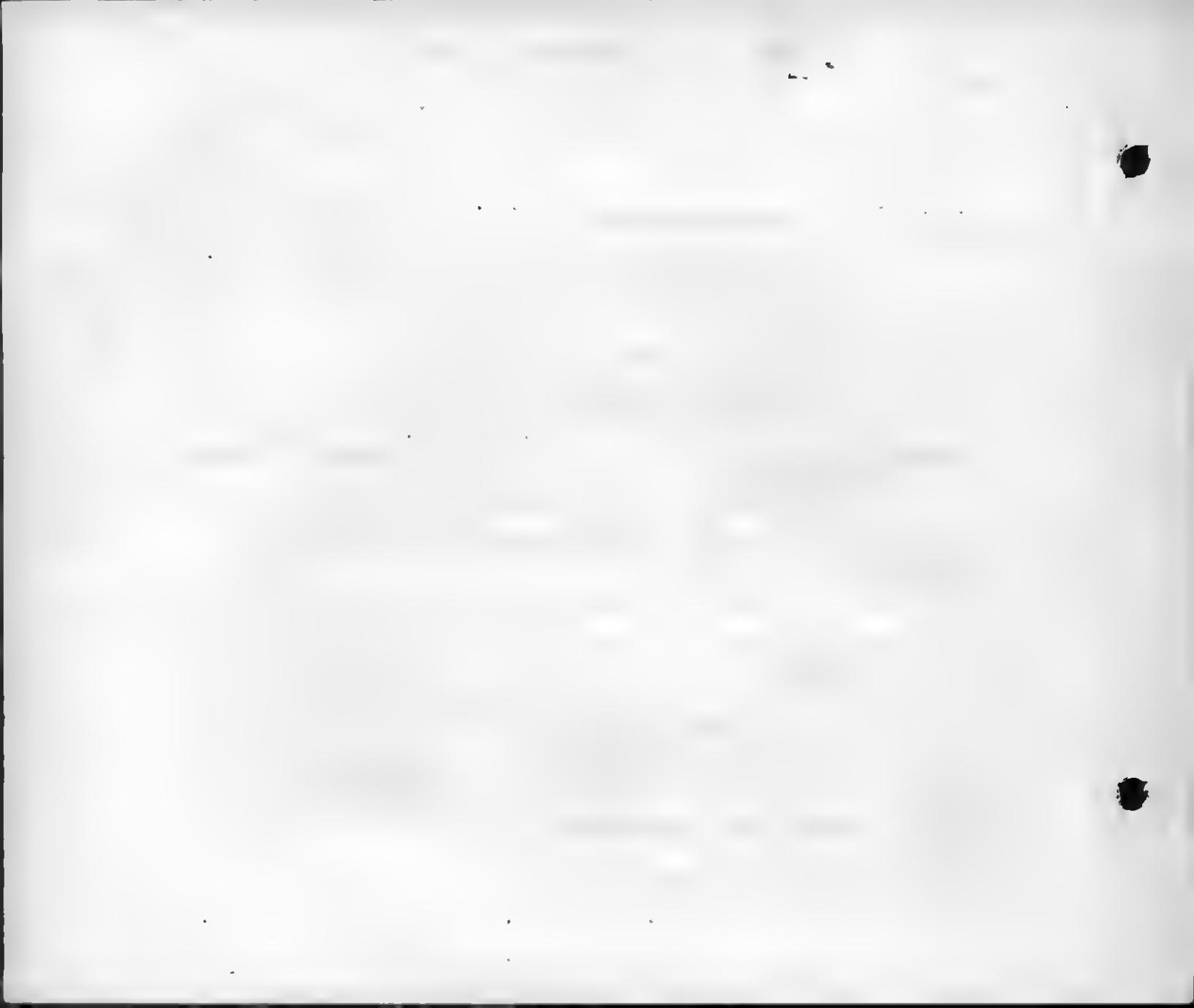
## CERTIFICATE OF DEATH

04407

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by \_\_\_\_\_ hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Hanover</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fallston</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. 2 - Box 74</b>		d. STREET ADDRESS <b>R. D. 2, Box 74</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>NELLIE</b>	First <b>NELLIE</b>	Middle <b>RUTH</b>	Last <b>MATTINGLY</b>		
4. DATE OF DEATH <b>APR. 23, 1959</b>	Month <b>APR.</b>	Day <b>23</b>	Year <b>1959</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1898</b>		
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>		
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Charles Bagley</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Virginia McCauley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or date of service) <b>none</b>	17. INFORMANT <b>Mr. Donald E. Mattingly - Box 74-R D 2, Fallston</b>	Address <b>Box 74-R D 2, Fallston</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  <b>1 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		<i>Coronary thrombosis</i> <i>Diabetes mellitus, mild</i> INTERVAL BETWEEN ONSET AND DEATH <b>1-2 hrs</b> <b>6-6 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Kingsville</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Jan. 1956</b> , 19____, to <b>April 27, 1959</b> , that I last saw the deceased alive on <b>April 28, 1959</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above ACTUAL SIGNATURE <i>Charles Bagley, M.D.</i> ADDRESS (Street, city or town, state) <b>Bellair Md.</b> DATE SIGNED PHYSICIAN'S NAME (Type) <i>Arthur S. Thorne</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/30/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. John's Cemetery</b>	22d. LOCATION (City, town, or county) <b>Kingsville, Md.</b>	(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stan. J. Tichner &amp; Sons - Baltimore</i>		24a. REC'D BY REGISTRAR DATE <b>APR 30 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 4425 CERTIFICATE OF DEATH

04408

Reg. Dist. No. ....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 11M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Harford Bel Air rural	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	1 Month		X STREET ADDRESS (If rural give location)
Harford convalescent Home			
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
Female		First: Gr 30 Middle: Miller Last: J. W. Miller	April 20 1959
SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	DATE OF BIRTH
Female	White	Married	April 5, 1971
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Saleswoman		None	15th & 1st Sts., Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John E. Ensor		Elizabeth Chilcoat	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT & ADDRESS			
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch. Cerebro-Vascular Disease</u> ? DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH 24h.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 19, 1959</u> , to <u>April 20, 1959</u> , that I last saw the deceased alive on <u>April 19, 1959</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above. <b>SIGNATURE</b> <u>Willard P. Hudson</u> M.D. <b>ADDRESS</b> (Street, city, town, state) <u>Forest Hill Md.</u> <b>DATE SIGNED</b> <u>April 20, 1959</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/22/1959	NAME OF CEMETERY OR CREMATORIAL Jarrettsville
24. REC'D BY REGISTRAR DATE APR 24 '59		REGISTRAR'S SIGNATURE Civilla S. House	LOCATION (City, town, or county) Jarrettsville Md.
		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kurt</u> Jarrettsville Md.	



FOR STATE  
HEALTH DEPT.

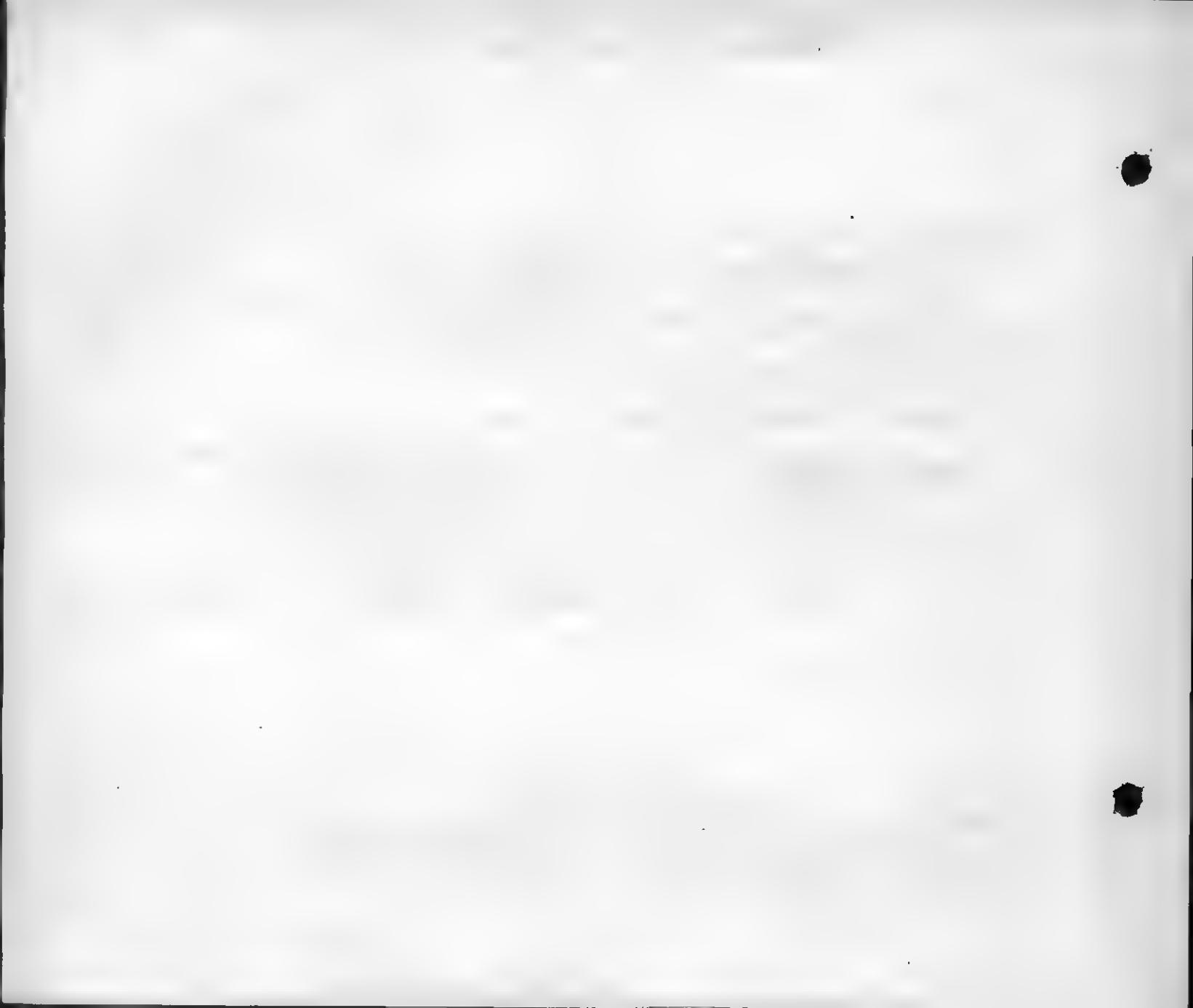
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4426 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md	b. COUNTY Harford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		d. STREET ADDRESS RD 2				e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Bel Air		18 years		c. LENGTH OF STAY IN lb	18 years		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		RD 2									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Bel Air		18 years		e. DATE OF DEATH	Apr 1 4		Month Day Year		f. IF UNDER 1 YEAR Months Days Hours Min.				g. IF UNDER 24 HRS					
3. NAME OF DECEASED (Type or print)	First Joseph		Middle Neal		Last Moretz		Age (in years last birthday) 68 yrs												
4. SEX M	6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb 13-1891		9. IF UNDER 1 YEAR Months Days Hours Min.												
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (State or foreign country) Ashe Co NC		12. CITIZEN OF WHAT COUNTRY? 45														
13. FATHER'S NAME William Moretz	14. MOTHER'S MAIDEN NAME Julia Trivett																		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO. 719-07-9810		17. INFORMANT MRS Ruby M Lewis Address Alongton Harford Rd Md Box 258																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Fracture Cervical Vertebra																		
812X	DUE TO																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)																		
	DUE TO																		
(c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
Crushing injury chest																			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		Antecedent auto pedestrian type																
20c. TIME OF INJURY Month Day, Year How 4-4-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 22		20f. (City or town) Bel Air (County) Harford (State) Md														
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Gerald C Palmer	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Bel Air, MD 4-4-59												
EXAMINER'S NAME (Type) Gerald C Palmer MD																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF APRIL 59		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Big Flatts Baptist		22d. LOCATION (City, town, or county) Fleetwood NC														
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Stots Bel Air Md																			
24a. REC'D BY REGISTRAR DATE APR 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause																	



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4427

## CERTIFICATE OF DEATH

04410

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carlington</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carlington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Henry H. Powers</i>		First	Middle
4. DATE OF DEATH <i>April 17, 1959</i>		Last	Month
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <i>Divorced</i> <input type="checkbox"/>
8. DATE OF BIRTH <i>Nov. 21, 1901</i>		9. AGE (In years month(s) day(s)) yrs. <i>57</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
10c. BIRTHPLACE (State or foreign country) <i>Ash Co., N.C., U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Address</i> <i>Mrs Henry Powers</i>	
13. FATHER'S NAME <i>Andrew J. Powers</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Caudill</i>	
15. WAS DECEASED EVER IN THE ARMED FORCES? (If yes, give war or dates of serv.) <i>No</i>		16. SOCIAL SECURITY NO. <i>245-14-0840</i>	
17. INFORMANT <i>Mrs Henry Powers</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart failure</i> DUE TO <i>Gardiner, Md</i> INT'L DATE OF DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO <i>1 yr</i> (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 3, 1957</i> , to <i>4/18, 1959</i> , that I last saw the deceased alive on <i>4/17, 1959</i> , and that death occurred at <i>1304 M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Darlington, Md</i> DATE SIGNED <i>4/20/59</i>	
ACTUAL SIGNATURE <i>Dudley Phillips</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>Dudley Phillips M.D.</i>		DARLINGTON, Maryland	
22a. BURIAL OR Cremation <i>Burial</i>		22b. DATE THEREOF <i>April 21, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Bell-Air Memorial Cemetery, Harford Co., Md</i>		22d. LOCATION (City, town, or county) (State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey, Darlington, Md</i>		24a. REC'D BY REGISTRAR DATE APR 21 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Turner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4407

## CERTIFICATE OF DEATH

04411

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Harford</b>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		b. COUNTY <b>Harford</b>	
c. LENGTH OF STAY IN lb <b>31</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>64 Mt. Royal Avenue</b>		d. STREET ADDRESS <b>64 Mt. Royal Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>MARTHA</b>		First <b>M.</b>	Middle <b>RAGAN</b>
4. DATE OF DEATH <b>April 26 1959</b>		Month <b>April</b>	Day <b>26</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>Sept. 6, 1875</b>		9. AGE (In years last birthday) <b>83 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>
11. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		12. MOTHER'S MAIDEN NAME <b>Mary Frances McVey</b>	
13. FATHER'S NAME <b>John Wesley Arrison</b>		14. MOTHER'S MAIDEN NAME <b>Mary Frances McVey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>_____</b>	17. INFORMANT <b>Mrs. Thomas Welsh, Aberdeen, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4344</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Pulmonary Embolus</b>			
(b) <b>Arterial Occlusion</b> DUE TO <b>Cardiac decompensation</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-11 1959</b> to <b>4-26 1959</b> , that I last saw the deceased alive on <b>4-21 1959</b> , and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>421 Congress Ave.</b>	
ACTUAL SIGNATURE <b>Gunther D. Hirsch</b>		DATE SIGNED <b>4-28-59</b>	
PHYSICIAN'S NAME (Type) <b>Gunther D. Hirsch, M.D.</b>		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/28/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>North East Cemetery</b>
22d. LOCATION (City, town, or county) <b>North East, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Harris —</b>		24a. ADDRESS <b>Tarring Funeral Home</b>	24b. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

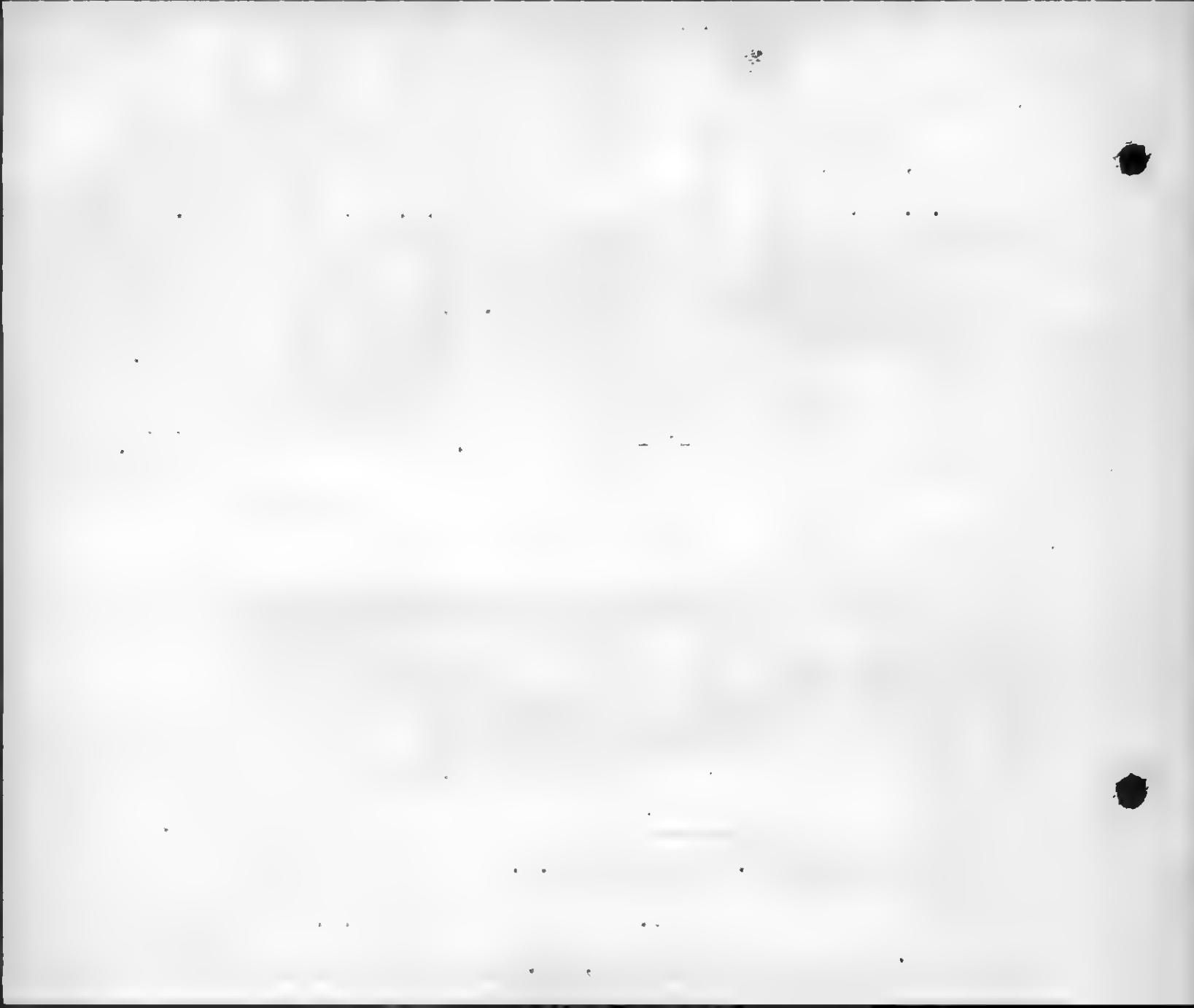
4428

## CERTIFICATE OF DEATH

04412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Aberdeen</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Aberdeen, MD</b>		d. STREET ADDRESS <b>R.D. #1, Gilbert Rd.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. #1, Gilbert Road</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First	Middle	Last	4. DATE OF DEATH <b>April</b>	Month	Day	Year <b>5 1959</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 5, 1864</b>	9. AGE (In years from last birthday) <b>94</b> yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA.</b>		
13. FATHER'S NAME  <b>Unknown</b>		14. MOTHER'S MAIDEN NAME  <b>Jane Tildon</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-14-3309</b>		17. INFORMANT <b>Annie R. Syckels</b>		Address <b>R.D. #1 Aberdeen, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Arteriosclerotic Heart disease with Failure</i>				INTERVAL BETWEEN ONSET AND DEATH		
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b)		<i>Pulmonary Fibrosis</i>						
DUE TO  (c) <i>Generalized Arteriosclerosis</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Dec. 12, 1958</b> to <b>April 4, 1959</b> that I last saw the deceased alive on <b>April 4, 1959</b> , and that death occurred at <b>30pm</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>569 Revolution St.</b>		DATE SIGNED
ACTUAL SIGNATURE <i>George T. Stansbury</i>		M.D.						
PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>		M.D.				Havre de Grace, Md.		
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/9/59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Calvary Cemetery</b>		22d. LOCATION (City, town, or county) <b>R.D. Aberdeen, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Julie E. Barrueg</i>		ADDRESS <b>Tarring Funeral Home</b>		24a. REGISTRAR BY REGISTRAR DATE <b>APR 10 59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thane</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4429

## CERTIFICATE OF DEATH

Reg. Dist. No. 11-413

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and/or any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel-Air</i>	c. LENGTH OF STAY IN 1b <i>8 yrs.</i>	b. COUNTY <i>Hanover</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel-Air</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.F.D.#1 Box 357</i>	d. STREET ADDRESS <i>R.F.D.#1 Box 357</i>		
3. NAME OF DECEASED (Type or print) <i>Harry Vincent Rose</i>		4. DATE OF DEATH Month <i>4</i>	Day <i>1</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH B. DATE OF BIRTH <i>9-11-1912</i>
9. AGE (In years last birthday) <i>46 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		11. BIRTHPLACE (State or foreign country) <i>Aberdeen Proving Ground, Red Star, W. Va.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Harry B. Rose</i>	
14. MOTHER'S MAIDEN NAME <i>Martha Bryant</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes 1942-1946</i>	
16. SOCIAL SECURITY NO. <i>236-05-3125</i>		17. INFORMANT <i>Mrs. Martha Boone - Bel-Air, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Acute Coronary Thrombosis</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO <i> </i>			
DUE TO <i> </i>			
DUE TO <i> </i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb. 27, 1959</i> , to <i>March 31, 1959</i> , that I last saw the deceased alive on <i>March 31, 1959</i> , and that death occurred at <i>2:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George J. Stansbury</i>		ADDRESS (Street, city or town, state) <i>M.D. 569 Revolution St., Hanover Grace, Md. 42159</i>	
PHYSICIAN'S NAME (Type) <i>George J. Stansbury</i>		DATE SIGNED <i>4/4/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-4-1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Clark's Chapel Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Hanover, Harford Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Olelio J. Bullock - Hanover Grace</i>		ADDRESS <i> </i>	
24a. REC'D BY REGISTRAR DATE APR 6 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

4408

## **CERTIFICATE OF DEATH**

04414

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Harford		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Bel Air		4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
722 S. Main St		1722 S. Main St	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
		Gladys	Scrippens
4. DATE OF DEATH		Month	Day
		April	13
		Year	1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
			B. DATE OF BIRTH
		Sept 29- 1920	9. AGE (In years (last birthday) yrs.
		38	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
		Housewife	Lansing N. Y.
12. CITIZEN OF WHAT COUNTRY?		45	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Calix W. Sexton		Bessie E. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT
		217-16-0590	John Scrippens Address 722 S. MAIN ST Bel Air MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Carcinoma R. breast with metastases 8 mos	
170X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO		(c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-15, 1959, to 4-13, 1959, that I last saw the deceased alive on 4-12, 1959, and that death occurred at 114 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Gerald C Palmer, M.D. Bel Air, Md. DATE SIGNED 4-19-59	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
Gerald C Palmer, M.D.		Gerald C Palmer, M.D. Bel Air, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF APRIL 16/59	22c. NAME OF CEMETERY OR CREMATORIAL Bartington
23. FUNERAL DIRECTOR'S SIGNATURE Joseph T. Foster, Bel Air, Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Harford Md.	
		24a. MORT. BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Joseph T. Foster, Bel Air, Md.	
		DATE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04415

4409

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ave de Grace</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Lloyd</i>	Middle <i>H.</i>	Last <i>Shue</i>		
4. DATE OF DEATH <i>April 6</i>	Month <i>April</i>	Day <i>6</i>	Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5 1900</i>		
9. AGE (In years last birthday) <i>58 yrs</i>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Auto.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Isreal Shue</i>		14. MOTHER'S MAIDEN NAME <i>Emma Kilbaugh</i>		Address <i>same as above</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>185-09-1878</i>		17. INFORMANT <i>Mrs Roberta Shue</i>	
18. CAUSE OF DEATH (Enter only one cause per line) for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>180X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO <i>Right nephrectomy</i> (c) DUE TO <i>Carcinoma R. Kidney</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>2 1/2 hrs.</i> <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterosclerotic Cardiovascular Disease with Coronary Thrombosis</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>fall from a ladder</i>			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>600 S. Union St.</i>	20f. (City or town) <i>Harford</i>	(County) <i>M.D.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>2-5 March 1957</i> , to <i>4-6 April 1957</i> , that I last saw the deceased alive on <i>6 April 1957</i> , and that death occurred at <i>7:25 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. H. Sadoway</i>					
PHYSICIAN'S NAME (Type) <i>J. H. Sadoway</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>April 9, 1957</i>	22c. NAME OF CEMETERY OR Crematory <i>New Freedom Cemetery</i>	22d. LOCATION (City, town, or county) <i>New Freedom, Pa.</i>	(State) <i>Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Harlanstein, New Freedom, Pa.</i>	ADDRESS <i>100 Main Street, New Freedom, Pa.</i>	24a. REC'D BY REGISTRAR <i>ARR B '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04416

Reg. Dist. No.

4410

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>CECIL</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAUTE DE GRACE</b>		c. LENGTH OF STAY IN lb <b>3 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		d. STREET ADDRESS <b>54 N. Main</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>		First	Middle	Last	4. DATE OF DEATH <b>April 1 3 1959</b>	Month	Day	Year		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>4-3-59</b>	8. AGE (In years (last birthday) yrs <b>2</b>	9. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>2</b>	Days <b>43</b>	Hours <b>2</b>	Min <b>43</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEWBORN</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Richard Slayman</b>			14. MOTHER'S MAIDEN NAME <b>HELEN Elizabeth SHOUE MAKER</b>		Address <b>same as above</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mother</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7:5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO C DUE TO (c) <b>EXTREME PREMATURITY (Birth wt 1#11g)</b> — <b>PARTIAL - SEPARATION OF PLACENTA (PREMATURE)</b> —			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 HRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>274</b>		20f. (City or town) <b>54. 3. 59</b>		(County) <b>1959</b>	(State) <b>Colo., Md.</b>
21. I certify that I attended the deceased from alive on <b>4/4/59</b> , 19 <b>59</b> , and that death occurred at <b>11:10</b> M, from the causes and on the date stated above.					ADDRESS (Street, city or town, state) <b>Perryville, Md.</b>		DATE SIGNED <b>4/4/59</b>			
ACTUAL SIGNATURE <b>B. B. Sherman M.D.</b>										
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMAINS (if any) <b>Burial</b>		22b. DATE THEREOF <b>4-4-1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>West Nottingham Cem.</b>		22d. LOCATION (City, town or county) <b>Colora., Md. Rural</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lil a. Patterson-Jones</b>			ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Tracy</b>			



## INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 4430 CERTIFICATE OF DEATH

14417

Reg. Dist. No.....

## 1. PLACE OF DEATH

COUNTY

HARFORD

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN WHITEFORD

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

MARYLAND

LENGTH OF STAY  
(In this place)

15 YRS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MD.

COUNTY

HARFORD

CITY (If outside corporate limits, write RURAL and give nearest town)

OR  
TOWNSTREET  
ADDRESS

WHITEFORD

(If rural give location)

3. NAME OF  
DECEASED  
(Type or Print)

(First) Catherine (Middle) Elizabeth (Last) Stewart

4. SEX

F

6. COLOR OR  
RACE

Cauc

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

W

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

House wife

8. DATE OF BIRTH

18 April 1879

9. AGE last birthday  
yrs.

79

IF UNDER 1 YEAR  
Months

0

IF UNDER 24 HRS.  
Hours

0

Min.

13. FATHER'S NAME

HENRY BROWNS BERGER

14. MOTHER'S MAIDEN NAME

REBECCA GOLDFUS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, No, unk.)

No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

FRANCIS H. STEWART, WHITEFORD, MD

INTERVAL BETWEEN  
ONSET AND DEATH

15 yrs +

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

Diabetes mellitus - c uremia.

ANTECEDENT CAUSE(S)  
DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

DUE TO

(B)

ARTERIOSCLEROTIC cardiovascular

DUE TO

(C)

disease

## 18. MEDICAL CERTIFICATION

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

NONE

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While  
at work  Not while  
at work 

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from Oct. 1957, to April 12, 1959, that I last saw the deceased alive on April 11, 1959, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

SIGNATURE

Edward Whiteford Jr. M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

4/12/59

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

4-16-59

NAME OF CEMETERY OR CREMATORI

ST. MARYS

LOCATION (City, town, or county)

PYLESVILLE, MD.

(State)

24. REC'D BY REGISTRAR

APR 14 '59

REGISTRAR'S SIGNATURE

C. Charles L. Thomas

25. FUNERAL DIRECTOR'S SIGNATURE

John H. Hartman, Wellton, Pa.

ADDRESS



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4411

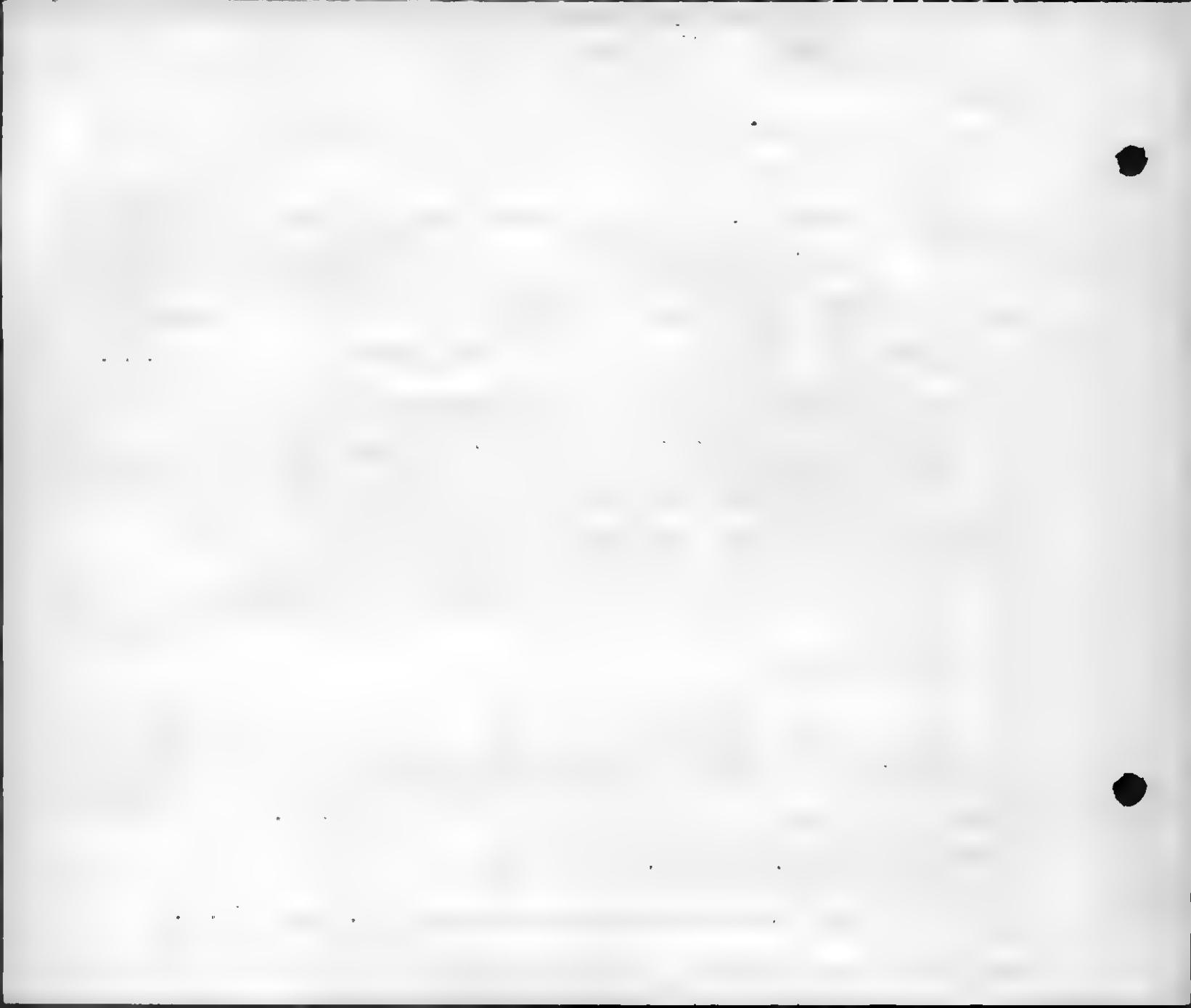
## CERTIFICATE OF DEATH

04418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland</b>				
c. LENGTH OF STAY IN 1b <b>33 years</b>				d. STREET ADDRESS <b>Bel Air</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>133 Thomas Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Coxa</b>	Middle <b>Lee</b>	Last <b>Suite</b>	4. DATE OF DEATH <b>April</b>	Month <b>16</b>	Day <b>19</b>	Year <b>59</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 13, 1888</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Lee Green Pilkins</b>				14. MOTHER'S MAIDEN NAME <b>Carolyn Casey</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-20-5596</b>				
17. INFORMANT <b>John A. Suite, Bel Air, Maryland</b>				Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>??</b>								
(b) <b>Cerebro-vascular Disease</b> DUE TO <b>??</b>								
(c) <b>??</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.		Month <b>19</b>	Day <b>10</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Forest Hill, Md.</b>	(County) <b>??</b>	(State) <b>??</b>
21. I certify that I attended the deceased from <b>April 10, 1959</b> , to <b>April 16, 1959</b> , that I last saw the deceased alive on <b>April 16, 1959</b> , and that death occurred at <b>10:00a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>4-17-59</b>								
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D.								
PATRICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Grove Baptist Church</b>		22d. LOCATION (City, town, or county) <b>Rt. #2, Bel Air, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Thorne</b>				24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>				
ADDRESS				24b. REGISTRAR'S SIGNATURE				

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 Hospital or attending physician.  
 Other this certificate has been signed by the attending physician and completely filled in by the medical director.  
 To Funeral Director: Please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME  
SM 2 57

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RO Rocks LENGTH OF STAY IN 1b 55 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x RURAL Rocks 1d STREET ADDRESS SHARON Rd	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SHARON Rd		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES Amos SWEETING		4. DATE OF DEATH APRIL 26 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH JULY 19, 1903	9. AGE (In years last birthday) 55 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) ROCKS, MARYLAND
13. FATHER'S NAME GEORGE W. SWEETING		14. MOTHER'S MAIDEN NAME EUGENIA AMOS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	17. INFORMANT WILSON SWEETING Address Rocks, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 47% DUE TO GUNSHOT WOUND ENTERING HEAD INSTANT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO THRU MOUTH UNDER TONGUE (c) DUE TO SUICIDE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH SUICIDE		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 7 a.m. APRIL 24 1959		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME
20f. (City or town) ROCKS, HARFORD, MD		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> (circled), Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE	PHILIP W. HEUMAN, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED APRIL 26, 1959
EXAMINER'S NAME (Type)	PHILIP W. HEUMAN, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF APR 27-59	22c. NAME OF CEMETERY OR CREMATORIAL Wm Waters	22d. LOCATION (City, town, or county) Eastown Brook, Md
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN & PORTER, J. L. RETAILLER		ADDRESS	24a. REC'D BY REGISTRAR APR 30 '59
			24b. REGISTRAR'S SIGNATURE Orlin & Karp



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Abingdon		c. STATE MD b. COUNTY Harford							
c. LENGTH OF STAY IN 1b		12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Otter Point Road		d. STREET ADDRESS Otter Point Road							
e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First Middle Lost		4. DATE OF DEATH April 22, 1959							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-76		9. AGE (in years from birth day) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Dorchester co. Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Moore		14. MOTHER'S MAIDEN NAME Florence Hurley									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO None		17. INFORMANT John L. Tefke		Address Box 132 Otter Pt Rd, Abingdon					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease						INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO									
		DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. (County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gerald C Palmer		DATE SIGNED 4-22-59									
EXAMINER'S NAME (Type) Gerald C Palmer MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-1959		22c. NAME OF CEMETERY OR CREMATORIUM Zion Lutheran		22d. LOCATION (City, town, or county) Stemmers Run, Balto. Co. Md					
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home		ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE APR 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4433

## CERTIFICATE OF DEATH

04421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>		c. LENGTH OF STAY IN 1b <b>9 yrs..</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa</b>		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Henry</b>		First	Middle	Last	4. DATE OF DEATH <b>April, 1 1959</b>	Month	Day	Year		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 2, 1897</b>	9. AGE (In years lost birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>				
13. FATHER'S NAME <b>Dave Tiller</b>					14. MOTHER'S MAIDEN NAME <b>Mary Barton</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>228-09-8132</b>		17. INFORMANT <b>Jettie B. Tiller,</b>		Address <b>Joppa, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Pulmonary Tuberculosis</b>										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <b>Eccrineoma of the Bladder</b>										
DUE TO <b>(Keratinizing type)</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>18.2 Eccrineoma of the Bladder</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>19.2 Pulmonary Tuberculosis</b>								
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Honaker, Russell Co., Virginia.</b>		(County)		(State)	
21. I certify that I attended the deceased from <b>Aug. 25, 1957</b> to <b>Apr. 1, 1959</b> , that I last saw the deceased alive on <b>Apr. 1, 1959</b> , and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Fork, Maryland.</b>								
ACTUAL SIGNATURE <i>Clifford F. Hudson</i>		DATE SIGNED <b>Clifford F. Hudson M.D.</b>								
PHYSICIAN'S NAME (Type) <b>Clifford F. Hudson</b>		Fork, Maryland.								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Apr. 3, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Gent Funeral Home</b>		22d. LOCATION (City, town, or county) <b>Honaker, Russell Co., Virginia.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard R. McComas Jr.</i>		ADDRESS <b>Abingdon, Maryland.</b>		24a. REC'D BY REGISTRAR <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				
VS A15 (4) 15M 9/55										

Q u a n t u

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4412

## CERTIFICATE OF DEATH

11422

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY HARFORD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE NEW MEXICO		b. COUNTY LEA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR		c. LENGTH OF STAY IN lb 1 WEEK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TATUM (RURAL)		d. STREET ADDRESS 12MILES EAST OF TATUM ON RT 380 Box 123			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 NO. KELLY AVE						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EUGENE		First	Middle	Last	4. DATE OF DEATH APRIL	Month	Day	Year	
5. SEX MALE		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT 27 1899	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RANCHER		10b. KIND OF BUSINESS OR INDUSTRY CATTLE		11. BIRTHPLACE (State or foreign country) MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME SIDNEY DANIEL WATKINS		14. MOTHER'S MAIDEN NAME FLORENCE CASSON							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 525-48-3485		17. INFORMANT (Son) WAYNE WATKINS		Address BEL AIR, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 20 MIN							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		CORONARY OCCLUSION							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost: (b)		CARDIAC INSUFFICIENCY							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>APRIL 27, 1959</u> , to <u>APRIL 30, 1959</u> , that I last saw the deceased alive on <u>APRIL 30, 1959</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Philip W. Neuman</u> M.D. <u>307 Hickory</u> ADDRESS (Street, city or town, state) <u>APRIL 30, 1959</u> DATE SIGNED									
PHYSICIAN'S NAME (Type) <u>Philip W. Neuman</u>		BEL AIR, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3/59		22c. NAME OF CEMETERY OR CREMATORIAL Chandler OKla.		22d. LOCATION (City, town, or county) Chandler (OKla.) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph William Trotter		ADDRESS West Broadway & Williams St. BEL AIR, Maryland		24a. REC'D BY REGISTRAR DA MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur & Trotter			



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-510M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****4434 CERTIFICATE OF DEATH**

04423

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY	Harford MARYLAND		STATE	Maryland COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Bel Air, R.D.	
TOWN	Kalmia-Bel Air R.D. Life		X TOWN	(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Forge Hill Rd/		STREET ADDRESS	Forge Hill RD.	
<b>3. NAME OF DECEASED</b> (First) Anna Mae Williams			<b>4. DATE (Month) (Day) (Year)</b> OF DEATH Apr. 23, 1959		
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 16, 1926	9. AGE last birthday 32	IF UNDER 1 YEAR Months Deys Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping			10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Harford Co., Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John W. Williams			14. MOTHER'S MAIDEN NAME Druescella Wilmore		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 215-28-8919		17. INFORMANT & ADDRESS Mrs. Emma V. Brooks Box 242A R.D. #1, Bel Air, Md.	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  241X IMMEDIATE CAUSE (A) Bronchial asthma ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____  <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from May 1953, to April 23, 1959, that I last saw the deceased alive on April 22, 1959, and that death occurred at 10:40 PM, from the causes and on the date stated above.</b>					
<b>SIGNATURE</b> Willard P. Hudson M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 27, 59		NAME OF CEMETERY OR CREMATORIAL Clarks Chapel	
24. REC'D BY REGISTRAR APR 27 '59		REGISTRAR'S SIGNATURE Collier S. Hause		LOCATION (City, town, or county) Kalmia, Harf. Co., Md.	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> Joseph W. Trotter W. Broadway and Williams St., Bel Air, Maryland					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4435

## CERTIFICATE OF DEATH

14424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall R.D.</i>		c. LENGTH OF STAY IN lb <i>80 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall R.D.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>/</i>		d. STREET ADDRESS <i>/</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Hugh</i>	Middle <i>Thomas</i>	Last <i>Williams</i>	4. DATE OF DEATH Month <i>Apr</i>	Day <i>25</i> Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 29 1876</i>	9. AGE (In years last birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Owner</i>		11. BIRTHPLACE (State or foreign country) <i>White Hall Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Frank Williams</i>		14. MOTHER'S MAIDEN NAME <i>Mary Amos</i>		Address <i>White Hall Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Tenora G. Williams</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i>		DUE TO <i>Cerebro-Vascular Accident.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio-Sclerosis, Generalized.</i>		DUE TO (c) <i>15 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>0.51.</i> Month <i>Apr</i> Day <i>25</i> Year <i>1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1, 1958</i> , to <i>April 25, 1959</i> , that I last saw the deceased alive on <i>April 25, 1959</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Stewartstown, Pa.</i> DATE SIGNED <i>4-25-59</i>					
ACTUAL SIGNATURE <i>William O. Fulton M.D.</i>					
PHYSICIAN'S NAME (Type) <i>William O. Fulton</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-28-59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Ayres Chapel Cem.</i>	
22d. LOCATION (City, town, or county) (State) <i>White Hall, Maryland</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Merton G. Gandy, Jamisonville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>APR 30 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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